Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Fort Worth

Respondent Name
Indemnity Insurance Co of North

MFDR Tracking Number
M4-14-3356-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
July 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please notice that prices were listed on ALL claim forms from the time of first submission until now. I'm taking the next step to get the rest of these claims paid and sending all documentation I have to MDR."

Amount in Dispute: $233.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written notification of medical fee dispute received however no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 17, 2013	99361, 97001	$233.08	$233.08

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out fee guidelines for workers' compensation specific services
3. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional medical services
4. 28 Texas Administrative Code §133.240 sets out guidelines for medical payments and denial
5. 28 Texas Administrative Code §133.20 sets out guidelines for medical claim submission by health care providers
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Bill received without Amount billed

Issues

1. Did the requestor submit a complete bill?

2. Did the carrier adjudicate the disputed services per Division guidelines?
3. What is the rule that pertains to fee guidelines?
4. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on July 16, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
2. The carrier sent correspondence to the requestor on December 12, 2013 that states, "Bill received without Amount Billed. Per 28 Texas Administrative Code §133.20 (e) A medical bill must be submitted:(1) for an amount that does not exceed the health care provider's usual and customary charge for the health care provided in accordance with Labor Code §§413.011 and 415.005;" Review of the submitted documentation finds medical claim with date 01/21/2014 that has total billed for line items related to 97001, G8987, and G8988. Also found was a claim for CPT code 99361 dated 10/24/2013 for a total amount of $113.00. Therefore, the Division finds the requestor did submit a complete bill.
3. Per 28 Texas Administrative Code §133.240(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation." No documentation was found to support the carrier took final action as required by Division guidelines. Therefore, the services will be processed per Division rules and fee guidelines.
4. Per 28 Texas Administrative Code §134.204(c) "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (annual conversion factor for date of service).
    - §134.204. Medical Fee Guideline for Workers' Compensation Specific Services(e) Case Management Responsibilities by the Treating Doctor is as follows: (4) Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows: (A) CPT Code 99361. (i) Reimbursement to the treating doctor shall be $113. Modifier "W1" shall be added. The total allowed amount is $113.00
    - Procedure code 97001, service date October 17, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.2 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.2. The practice expense (PE) RVU of 0.95 multiplied by the PE GPCI of 0.979 is 0.93005. The malpractice RVU of 0.05 multiplied by the malpractice GPCI of 0.826 is 0.0413. The sum of 2.17135 is multiplied by the Division conversion factor of $55.30 for a MAR of $120.08. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $120.08.
5. The total allowable reimbursement for the services in dispute is $233.08. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $233.08. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $233.08.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $233.08 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		January , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.